REVIEW

Individuals with Threatening or Violent Criminal Behavior: Civil Commitment or Release After Incarceration?

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ABSTRACT

Patients who have diagnoses of a major mental illness and an antisocial personality disorder present administrative, clinical, legal, and ethical challenges. Based on an actual case, the authors discuss how clinicians could fulfill the obligation to the patient, mental health system, judicial system, and the community under these circumstances. We explore how clinical presentation of symptomatology and criminal behavior contribute to challenges in determining psychiatric care.

INTRODUCTION

Since the 1950s, the number of patients residing in and admitted to psychiatric centers has been in decline. More recently, however, this trend has shifted such that there is an increase in admissions, and patients are entering from the criminal justice system with major mental disorders like schizophrenia and affective disorders.[1] What can and should be done when an individual is admitted to a psychiatric setting from a criminal justice setting? What are the administrative and clinical issues that influence recommendations for continued inpatient treatment, discharge with outpatient treatment, and/or outright discharge?

The mission and purpose of psychiatric centers have changed significantly over 60 years. In the past, psychiatric centers in the United States were the designated places where those with chronic mental illness could receive treatment; some facilities provided care over long periods of time. With the advent of psychotropic medications, rehabilitative therapies, and the civil liberties movement, the chronically mentally ill patients discharged from large psychiatric

centers started their return to the community. In 1963, there was the creation of community mental health centers meant to replace custodial institutional care often associated with state psychiatric centers. When the Supreme Court ruled in the 1999 Olmstead decision that "unjustified isolation" of individuals with disabilities in institutions is a violation of the Americans with Disabilities Act,[2] changes in where and how treatment is conducted had legislative and judicial action. All of the above transformed psychiatric centers.

As people were discharged from facilities, the community treatment centers and support services became overwhelmed. At the same time, individuals who remained in the hospital became increasingly more challenging to place in the community.[3] The ultimate goal of treatment is to transition individuals to the least restrictive treatment and living setting.

The New Freedom Commission findings of Hogan et al[4] emphasizes that people recover and are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. The question many clinicians become concerned with is, what becomes of those individuals whose mental illness responds to medications but their antisocial behavior leaves them and the community at risk if they are discharged? The same question stands for those individuals who have symptoms and behaviors that do not respond to medication, such as paranoid ideation that is not delusional. Where and how are these individuals best treated—if they require treatment at all?

CASE REPORT

Mr. P. was a 45-year-old Caucasian man who was an inpatient at a state psychiatric facility. His history included psychiatric hospitalizations beginning when he was 36 years old with varying diagnoses of schizophrenia, schizoaffective disorder, and bipolar disorder, as well as antisocial personality disorder. He was involuntarily psychiatrically admitted following completion of the inmate portion of a sentence served in a state correctional facility for making a terrorist threat to a college campus. This 2010 admission occurred because Mr. P. was deemed dangerous to himself or others according to New York State's Mental Hygiene Law (9.27) and he was issued a civil commitment. He was on post-release supervision (parole) for this offense. Mr. P.'s other numerous arrests dated back to 2003 including weapons possession, an order of protection taken out by his mother, and a terrorist threat (leading to his current sentence).

Legal aspects. The parole followed Mr. P.'s conviction for leaving a voicemail threat at his alma mater college stating he would use an M-16 on fully automatic fire "until nothing was left standing." Mr. P. admitted to making this phone call and attributed his anger to an incident that happened to him four years prior. When arrested, Mr. P. stated he hated everyone in the college. The investigator assigned to his case commented Mr. P. knew what he was doing, and Mr. P.'s parents believed Mr. P. capable of carrying out his threats. On the other hand, the arresting officer stated Mr. P. demonstrated disorganized speech, had a note that appeared to be an itinerary: "deliver storage, get a ticket, follow up with friends, see college, forget and prayers," and had Air France flight numbers and times for flights from Boston to Paris and an itinerary for a round trip ticket from Boston to the site of the college. During the investigation Mr. P. stated his, "message was misinterpreted to mean that I reinterpreted the re-enactment of the Virginia Tech shooting," which occurred three weeks prior to his threat. Mr. P. was imperturbable regarding his right to have a college pool pass, made comments about going through his lawyer to obtain the pool pass and to do, "the same re-enactment that I have been talking about all along." This demonstrated Mr. P.'s potential danger to the college community.

Psychiatric aspects. Mr. P. had a history of multisystem use, including the Veterans Administration Medical Center, Social Security disability, the criminal justice system, and the psychiatric care system from the late 1990s through the present. His records documented that his father, a physician, continued to advocate for antipsychotic medication treatment for his son stating that Mr. P. had a long history of "run-ins with the law," including angry and belligerent behavior, and that he was dangerous. He described his son as having rapid mood shifts and irritability. Other consistent problematic behaviors included lack of motivation, poor hygiene, and inability to obtain and maintain employment.

Available discharge summaries described Mr. P. as generally guarded and evasive; however, he did not meet the criteria for commitment. It was determined that he could benefit from psychiatric medications; however, during the hospitalization and at discharge he refused medication. Mr. P. reported at some point he had accepted psychiatric medications although there was no evidence supporting this claim. Mr. P. denied alcohol or other recreational drug use. He had an unremarkable medical history although he was preoccupied with his psoriasis.

Mr. P. never married and had no children. His religion was listed as Christian Science (although not substantiated), which he occasionally stated was his reason for refusing antipsychotic medication.

When asked about his hospitalizations, interests, birthplace, or members of his family, Mr. P. refused to give details, stating, "I don't know how that is relevant." Mr. P. denied any family psychiatric history although his father stated

alcoholism runs in the family and Mr. P.'s brother committed suicide. Records indicated Mr. P. completed a bachelor's degree in Economics (1991) and a master's degree in Liberal Arts (1996).

Transition to state psychiatric center. While in prison it was learned that Mr. P. received psychiatric treatment in the past and was evaluated by a mental health specialist. Aside from regular psychiatric evaluations, Mr. P. did not attend any particular mental health program in prison, nor did he take recommended and prescribed psychotropic medications. He denied having any mental illness. Mr. P. apparently functioned adequately in the highly structured environment of prison. He was described as friendly, cooperative, and spontaneous on examination until his crime was mentioned, at which point he became constricted, vague, and evasive.

Mr. P.'s behavior and need for treatment were not addressed until his release from prison was imminent. One month before release, he was evaluated by representatives from the Office of Mental Health including a senior psychiatrist, chief psychologist, and a forensic unit chief. Results of psychological testing demonstrated Mr. P.'s oppositional characteristics and severe psychological impairment and defensiveness. The Certificate of Examining Physician completed by the prison psychiatrist concluded:

> *In summary, Mr. P. presents with a history of violence, who refuses treatment, has been extremely guarded and suspicious, portrays himself in a favorable light on psychological testing, who is well controlled and minimizes his violent history. Although the psychological test results and interviews with mental health staff described Mr. P. as suffering from schizotypical personality disorder, this writer feels that a diagnosis of schizophrenia, paranoid type, is warranted based on the information provided.*

Further psychological testing at the state psychiatric center found no formal thought disorder. As demonstrated by the prison psychiatrist's statement, the Axis I and Axis II diagnoses vary and carry divergent options to determine treatment and planning for living settings. Clinicians were very concerned about the plan for this patient as Mr. P. had demonstrated he was dangerous. Mr. P. was released from a state correctional facility to a state psychiatric center for psychiatric stabilization.

Mr. P.'s behavior in unstructured settings included chronic conflicts with everyone he was in contact with and interpretations of interactions as being a threat to him. Mr. P. then acted on his interpretations, justifying his problematic responses as always necessary. He regularly externalized blame and stated in court that he did not believe the law applied to him.

RETENTION

Keeping an individual in a psychiatric facility is one side of the issue. Psychotic symptoms had not been established to a certainty in this case, yet psychotic symptoms alone do not, in and of themselves, dictate the need for that level of care. Retaining someone as an inpatient can be determined by an individual's inability to provide for himself or be a threat to himself or others. Threats of violence, depicted as protecting and defending oneself, could be seen as a threat to others and therefore meeting the criteria for hospitalization.

Behaviors of concern include not truthfully describing intentions or actions. Refusing to discuss life experiences and refusing to be involved in treatment not believed as needed, in addition to deceit, absence of cooperation, and history of dangerous behaviors, raises the question, "Is retention the answer?"

Individuals with antisocial and paranoid behaviors do pose a threat to others when their behaviors emanate from misinterpreting benign or mildly less-than-ideal interactions. This could cause justified actions as necessary to responsibly protect self, frequently using weapons. These behaviors would be expected to continue without retention that would offer effective interventions. It could be a complete surprise to a member of the community to be threatened as a response to an interaction. Therefore, retaining someone with these behaviors would protect members of the community.

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There is a chance that psychopharmacology could be impactful for these circumstances of paranoid personality disorder versus antisocial personality disorder. If psychiatric medication could be effective—to whatever degree—in addressing problematic behaviors, the individual would have to either agree to treatment or the psychiatric facility would have to seek treatment over the patient's objection. A reasonable length of time receiving psychiatric medication as treatment (i.e., 6–8 weeks) could be attempted to try to address a difficult situation.

Medication useful for violence typically targets symptoms of a specific diagnosis or behavior. Examples include treating paranoid behavior with antipsychotic medications, treating impulse control issues with selective serotonin

reuptake inhibitors (SSRIs) and some anticonvulsants, and treating violence from impulse control issues with high-dosebeta blockers and clozapine. Antidepressants have also been studied to impact violent behaviors but have shown only minimal effects. A recent meta-analysis of randomized, controlled trials that evaluated the effect of pharmacotherapy in borderline personality disorder found that antipsychotics and mood stabilizers may have beneficial effects in treating symptoms of psychopathology.[5]

Antipsychotics haloperidol and olanzapine were found to have a significant effect in the reduction of anger. Aripriprazole also provided a positive effect in treating this symptom as well as in treating impulsivity and interpersonal problems. In addition, the second-generation antipsychotics stated above provided a reduction in cognitive perceptual symptoms (e.g., paranoia). Three mood stabilizers, specifically valproate, topiramate, and lamotrigine, produced a significant effect in treating anger. The first two also helped in treating interpersonal problems and the latter helped with impulsivity. However, it is important to note that the studies in this meta-analysis had small samples with the exception of two trials.[5] Thus, further research is still needed.

There was an earlier meta-analysis conducted on pharmacotherapy[6] with core traits of borderline personality disorder that showed antidepressants and mood stabilizers were effective in treating anger. However, the more recent meta-analysis[5] questioned the evidence supporting effectiveness of antidepressants in these symptoms. The earlier study[6] also showed that antipsychotics were effective with impulsivity, aggression, and interpersonal relationships and this was confirmed by the more recent meta-analysis.[5]

Retention promotes the perception of safety for the patient and for members of the community. In a structured environment, such as a psychiatric facility, individuals with paranoid and impulsive behaviors could be protected from incidents where community members may respond to their antisocial behaviors in a harmful manner. Behaviors and symptoms may bring them negative attention and involve them in incidents that could deteriorate to violence. Retention could limit this possibility to a greater extent than discharge.

Civil commitment depends upon the patient manifesting imminent danger of suicidality, homicidality, or grave disability in order to justify removing that individual's civil liberties with required psychiatric hospitalization.

If a thought process disorder is present, the individual could be treated while retained and has the potential, therefore, to no longer be a threat. Determination of whether the individual has a thought process disorder—or not—directs clinical practice. Retention provides a depth of therapeutic contact, behavioral reinforcement of effective interactions, arrest of the degenerative processes of illness through psychopharmacology, and resolution of poor problem solving life skills. One study[7] looked at whether untreated psychiatric symptoms could be the main source of criminal behavior and whether linkage with psychiatric services would be the solution. The results indicated that criminal behavior chiefly was driven by hostility, disinhibition, and emotional reactivity and that treatment targeting impulsivity and other common criminogenic behavior may be needed to prevent criminal recidivism.

If a thought process disorder is not present, the individual is not delusional or psychotic, but instead has a paranoid personality disorder with narcissistic and grandiose traits, it is likely the individual may deteriorate and become even less able to control behavior in response to distorted interpretations of interactions. This will make the individual extraordinarily dangerous in acting out to protect against a perceived threat, which can occur quite often when not in a structured environment. Mental health crises occur every day and too often result in harm to self or suicide.[8] In that case, the individual could be retained for the duration of parole to act on the obligation to the individual and society.

The explanation for retention would be that we do not know how dangerous the individual could be if there is a refusal on the patient's part to divulge pertinent and truthful details. Clinical judgment would err on the side of caution when there is an absence of data about how the individual can be safely discharged.

According to New York State Correction Law Section 402, an inmate manifesting symptoms of mental illness qualifies for examination by two examining physicians. Results of these examinations are presented to the court and can result in an order to commit such inmate to a hospital for the mentally ill. Civil commitment depends upon the patient manifesting imminent danger of suicidality, homicidality, or grave disability in order to justify removing that individual's civil liberties with required psychiatric hospitalization. Grave disability is defined as a refusal or inability to meet essential needs for food, shelter, clothing or healthcare (New York State Mental Hygiene Law Section 9.37). Extended psychiatric hospitalization and medication or other psychiatric treatment, over the individual's objection, requires specific court action due to the impingement on core civil liberties. Individual

freedoms, the need for treatment, and the risk to others are all weighed to provide the best set of circumstances for all concerned. The core value of psychiatric civil commitment remains consistent in that the individual must pose an imminent danger to self or others.

Once parole is completed, further retention may be sought. The rationale for further retention is that clinicians do not have sufficient evidence to certify whether the individual may be a danger to himself or others. In some states, courts impose on therapists a duty of care to assess whether the patient is capable of causing harm. Treating clinicians may be held accountable for patients' crimes even when treatment was mandated, sound, and met the professional community's standards of care.[9] Retaining an individual until there are reliable assurances about safe behaviors in the community seems the answer to many.

The administrative issue involved in retention, and the outcome of that decision, could be an expression of the system members' concerns about taking the responsibility of putting community members and an individual at potential risk. Retention could also assure the system is active and effective in determining and keeping someone who needs structure and treatment. The mental health provider community has accountability to the public in general to insure discharged patients are no longer dangerous to themselves or others.

Depriving a citizen of his or her civil liberties stemming from concern about what may possibly be a threat to public safety has not been routinely upheld by case law.[10] Personality disorders involving sex offenses are the exception in this regard.[11]

DISCHARGE

There are contradictory rulings in our justice system regarding the level of menace posed to the community and the community's right to act on the risk of menace. These determinations can be made outside healthcare or mental healthcare settings. As discussed above, civil commitment statutes allow the state to remove individuals' liberties due to mental illness and dangerousness. Determinations for civil commitment are left to be defined largely on a case-by-case basis by clinicians charged with making decisions about involuntary hospitalization. Variation in a given statute's applications are driven not so much by variance in the judgment of clinicians as by a range of social, political, and even economic factors.[12]

In situations where there is a question regarding mental health symptoms, assumptions of dangerousness involve careful assessment and predictions of risk in a different framework. If a mental healthcare provider deems someone's behavior to be a threat and this runs counter to the individual's own view of his or her situation, whose determination should dictate? The current state of mental health services in the Unites States can be characterized as being paternalistic or parental. Mental healthcare providers determine what is needed and then proceed to seek legal support to enforce their position. With no proximate dangerousness, agencies tend to act to remove liberties when there is little legal right to do so but instead have an intense distaste or dislike of the behavior.

If an individual is refusing treatment, and evaluations do not indicate the potential for imminent harm to self or others, the individual could be released on supervised release (parole/probation) if it has not been already completed or fulfilled. Psychiatric stability or remission of symptoms contribute to the notion that the individual has the ability to function well in the community. Inpatient retention, if refusing treatment, would not provide any additional benefit to the situation.

Behavior while a patient is hospitalized could contribute to a decision to discharge an individual if cooperative and courteous to peers and staff, and the post-release plan includes community monitoring. It happens often that individuals with certain behavioral problems respond well to the structure of the facility. Because psychiatric diagnoses have a subjective component and vary among clinicians, it can be difficult to be absolute concerning disposition.

If the individual does not have psychiatric symptomatology, and behavior is solely a result of antisocial personality and perceptions of interactions, then behaviors outside the law should not be addressed with psychiatric hospitalization, but by the judicial system. If the individual's personality is such that antisocial interactions such as contentiousness and conflict are routine aspects of being in the world, the individual is responsible for his behavior. In that circumstance, he also may not be able to be treated effectively with any psychiatric medication that would address these behaviors.

An administrative decision to discharge an individual would incorporate the available resources necessary and suitable for the diagnosis. Options for discharge could include versions of supervised outpatient contacts such as Assisted Outpatient Treatment (AOT) and Assertive Community Treatment (ACT). Both offer structure and monitoring, however many areas do not have these options or there are few features of the program. A growing body of literature indicates that specialty agencies hold promise for improving clinical and criminal outcomes for probationers and parolees with mental illness.[13]

A relevant administrative reality is that more than 80 percent of states report a shortage in psychiatric beds, 34 states report a shortage of acute care beds, 16 states report a shortage of long-term care beds, and 24 states report a shortage of forensic beds. As a result, 27 states

report longer waiting lists for inpatient psychiatric services and 14 states are struggling with overcrowding in public psychiatric facilities.[4] Serving the community and the individual under circumstances such as Mr. P.'s presents competing demands on dwindling and limited resources.

CONCLUSION

Clinical questions such as, "Is this patient's threatening and violent behavior criminal or is it a psychiatric symptom?" deserve careful consideration and discussion. Making that determination sets the stage for how to address these types of situations.

There are a number of contributing factors in considering the best course of action. Some of them include whether there indeed is a mental illness, if there is a mental illness is that the cause of any behavioral difficulties and risks to others, and is there satisfactory treatment available for the mental illness. Further issues to be incorporated into thoughtful decision-making is the definition of a person as having a mental illness and as being a criminal, and the sorting process used by the court system to determine whether a person with a mental illness will be sent to a prison or to a state psychiatric hospital.[1]

The process recommended by the authors includes clinical case conferences, consultation, ethics discussions, and case-by-case determinations of available options. This paper discusses psychiatric symptoms and the choices to treat and where to treat. To completely address the issue, consider that it is true that in the absence of psychiatric symptoms of dangerousness, violent behaviors do occur. What is to be done in that case?

The pros and cons of both paths (retention vs. discharge) have been presented to stimulate a dialogue about the decisions to be made by mental health care providers. The ethical dilemma is real. The impacts of quality of life for the individual and the safety of the community are at stake with decisions in either direction. Current events in January 2011 in Tucson, Arizona, make the ramifications of this type of decision regarding continued hospitalization palpable in our real-world experiences.

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